STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING _____ B. WING _____	C 02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON ROAD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00085707.

Complaint IN00085707-Substantiated, Federal/State deficiencies related to the allegations are cited at F279, F323, F514 and F9999.

Survey dates: February 14, 15, 16, and 17, 2011

Facility number: 011596
Provider number: 155769
AIM number: N/A

Survey team:
Betty Retherford, RN, TC
Ginger McNamee, RN
Karen Lewis, RN

Census Bed Type:
SNF: 56
Residential: 29
Total: 85

Census Payor Type:
Medicare: 32
Other: 53
Total: 85

Sample: 14
Residential Sample: 7

These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.

Quality reviw completed on February 21, 2011 by Bev Faulkner, RN

RECEIVED
MAR 10 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies.

The plan of corrections is prepared and executed solely because it is required by the position of Federal and State Law.

The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint and Annual Survey of February 17, 2011.

Please accept this plan of correction as the provider's credible allegation of compliance.

The Provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.

approved 3/23/11 RK
acceptable request for desk review 3/10/11 RK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynda A Koch | TITLE: Executive Director | (X6) DATE: 3/8/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set Assessments were completed accurately in regards to resident falls for 3 of 11 residents reviewed for accuracy of Minimum Data Set Assessments in a sample of 14. (Resident #'s B, C, and F)	F 278	**F 278** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B quarterly MDS ARD of 1/20/2011 was corrected to accurately reflect that resident had had a fall since the prior assessment on 11/5/2010. Resident C quarterly MDS ARD of 12/20/10 was corrected to accurately reflect the number of falls the resident had with no injury, injury or major injury since the prior assessment on 10/8/10. Resident F quarterly MDS ARD of 1/30/2011 was corrected to accurately reflect the number of falls the resident had with no injury, injury or major injury since the prior assessment on 11/13/10.	

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F 278	Continued From page 2 Findings include: 1. Resident #B's clinical record was reviewed on 2/14/11 at 1:00 p.m. The resident's diagnoses included, but were not limited to, vascular dementia without behaviors, symbolic dysfunction, diabetes mellitus type II. The resident had a 1/20/11, quarterly Minimum Data Set [MDS] assessment. The assessment indicated the resident had no falls since the prior assessment on 11/5/10. Review of the "Fall Circumstance, Assessment And Intervention" form, dated 12/29/10, indicated the resident had fallen at 7:45 a.m., on that date with no injury. During an interview with the Corporate Nurse on 2/16/11 at 1:03 p.m., she indicated she was aware of the MDS assessments not being coded correctly for falls. 2. Resident #C's clinical record was reviewed on 2/16/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, vertebral compression fracture, osteoporosis, pelvic fracture, and spinal stenosis. Resident #C had a 12/20/10, quarterly Minimum Data Set [MDS] assessment. The assessment indicated the resident had fallen since the prior 10/8/10, admission assessment. The boxes in the section of the assessment related to the number of falls with no injury, injury, and major injury were all coded as "0". Review of the "Fall Circumstance, Assessment	F 278	**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Clinical Care Coordinators will review the most recent MDS of residents with falls for past 30 days to ensure the accurate coding of falls and fall related injury since the prior assessment. Any MDS found to be coded inaccurately will be corrected by the Clinical Care Coordinators.	

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F 278	Continued From page 3 And Intervention" forms indicated Resident #C had fallen four times during the period between assessments and had injury with two of the falls occurring on 11/18/10 and 11/27/10. During an interview with the Corporate Nurse on 2/16/11 at 1:03 p.m., she indicated she was aware of the MDS assessments not being coded correctly for falls. 3. Resident #F's clinical record was reviewed on 2/16/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, hypertension, and seizure verses dystonic disorder. The resident had a 1/30/11, quarterly Minimum Data Set [MDS] assessment. The assessment indicated the resident had fallen since the prior 11/13/10 quarterly MDS assessment. The boxes in the section of the assessment related to the number of falls with no injury, injury, and major injury were all coded as "0." Review of the "Fall Circumstance, Assessment And Intervention" forms indicated Resident #F had fallen three times during the period between assessments. Two of the falls were with no injury and one fall occurring on 11/26/10 indicated the resident had injury and redness to the back of her head. During an interview with the Corporate Nurse on 2/16/11 at 1:03 p.m., she indicated she was aware of the MDS assessments not being coded correctly for falls.	F 278	**Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Clinical Care Coordinators on section J 1700, J 1800 and J 1900 of the RAI Version 3.0 Manual for accurate coding of falls and fall related injury since prior assessment. **How the corrective measure will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will audit 5 MDS per week times 60 days to ensure accurate coding of falls and fall related injury since prior assessment. Any inaccuracies noted will be corrected. The results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent applications of guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines. **Date: March 19, 2011**	
F 279	3.1-31(i) 483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 4 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed for 3 of 14 residents reviewed for development of comprehensive care plans in a sample of 14. (Resident #'s B, D, and E) Findings include: 1.) The clinical record for Resident #B was reviewed on 2/14/11 at 1:00 p.m. Diagnoses for Resident #B included, but was not limited to, Alzheimer's disease, diabetes mellitus,	F 279	**F 279** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B was discharged 1/28/2011. Resident D plan of care was updated to include refusal of meds / eye drops and interventions were listed to include encourage the resident to accept her medications and the potential problems to be monitored related to her refusal to accept her medications. Resident E plan of care was updated to include compression fracture and interventions were listed from the home care instructions provided to the campus by the hospital.	

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F 279	Continued From page 5 and vascular dementia with behaviors. A nursing note entry, dated 10/7/10, indicated Resident B's little toenail was loose and sore on her left foot. The note indicated the physician was contacted and a request was made for the resident to see the podiatrist. A podiatry form, dated 10/20/10, indicated Resident #B had been seen by the podiatrist on that date. The form indicated the resident had thickened toenails which were yellow and crumbly. The form indicated the toenails had incurved nail borders and painful nail borders. The form indicated podiatry care was given. A podiatry form, dated 1/5/11, indicated the resident was seen again on that date for the same concerns. Both forms indicated lotion should be applied to the feet after every shower. The clinical record lacked an comprehensive health care plan having been developed related to the resident being a diabetic with a history of a loose toenail and problems with her toenails requiring podiatrist intervention. During an interview with the Director of Nursing on 2/15/11 at 3:00 p.m., additional information was requested related to the lack of any comprehensive health care plan having been developed for Resident #B's toenail and podiatry concerns. During an interview on 2/16/11 at 10:00 a.m., the Director of Nursing indicated she was unable to provide any comprehensive health care plan for Resident #B's podiatry concerns. 2.) Resident #D's clinical record was reviewed on	F 279	**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Clinical Care Coordinators will review Medication Administration Records for past 30 days to identify resident medication refusal. Will then ensure a care plan is in place for medication refusal. Clinical Care Coordinators will review 24 hour reports for past 30 days to identify resident with diagnosis of fracture. Will then ensure a care plan is in place for the fracture. Clinical Care Coordinators will review last podiatry notes on each resident to identify residents with toenail problems requiring podiatry intervention. Will then ensure a care plan is in place for the toenail concerns.	

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F 279	Continued From page 6 2/14/11 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, osteoporosis, dementia, and glaucoma. The January 2011 Medication Administration Record (MAR) indicated Resident #D refused medications and/or eye drops almost daily. The MAR indicated the resident had orders for two eye drops for Glaucoma. The MAR indicated the resident refused a total of 41 doses of the eye drop medications during the month on January. The MAR indicated the resident had orders for seven oral medications. The MAR indicated the resident had refused a total of 149 doses of the oral medications. The clinical record lacked any comprehensive health care plan related to the resident refusing her medications and/or eye drops, approaches to be used to encourage the resident to accept her medications, and/or potential problems to be monitored related to her refusal to accept her medications. During an interview with the Administrator and Director of Nursing on 2/15/11 at 3:00 p.m., additional information was requested regarding the lack of health care planning for Resident #D's refusal to take her medications and or eye drops. During an interview on 2/16/11 at 10:00 a.m., the Director of Nursing indicated she was unable to provide any health care planning related to Resident #D's refusing medications and/or eye drops. 3.) Resident #E's clinical record was reviewed on 2/15/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to falls and compression fracture of the spine.	F 279	**Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the care plan team on the campus guideline Interdisciplinary Team Care Plan Guideline. **How the corrective measure will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will audit 3 care plans per week times 60 days to ensure a comprehensive careplan is in place related to resident with fractures, toenail problems that required podiatry intervention and medication refusal. The results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent applications of guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines. **Date: March 19, 2011**	

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F 279	Continued From page 7 Review of a 1/25/11, "Fall Circumstance, Assessment and Intervention" indicated the resident fell at 1:25 a.m. on 1/25/11. Review of a 1/25/11, 4:37 a.m., "Emergency Department Discharge Instructions" indicated the resident had a compression fracture of one of the bones in his spine. Some home care instructions included, but were not limited to: avoid prolonged sitting; during the first two days after injury apply an ice pack for 20 minutes every two to four hours to reduce swelling and pain; heat (hot shower, hot bath or heating pad) works well for muscle spasm; start with ice, then switch to heat after two days. Review of the resident's plan of care lacked any reference to the compression fracture. During an interview with the Director of Nursing and the Corporate R.N. on 2/16/11 at 1:03 p.m., they indicated there was no information related to the resident's compression fracture in the resident's plan of care. 4.) Review of a current revised facility policy, dated 1/08, provided by DoN on 2/16/11 at 12:58 p.m., titled "INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE", included, but was not limited to, the following: "PURPOSE: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. PROCEDURE:... ...f. The comprehensive care plan should be revised to reflect change in condition updates with	F 279		

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F 279	Continued From page 8 each MDS assessment.... ...h. The care plan should be reviewed and revised as needed with each MDS assessment.... ...j. New problem areas should be printed and added to the existing care plans...." This federal tag relates to Complaint #IN00085707. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)	F 279		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident identified at risk for falls had a safety alarm on as ordered by the physician for 1 of 6 residents in a sample of 14 reviewed for application of interventions to prevent falls resulting in a fall requiring transfer to the emergency room and treatment for lacerations and a cervical 3 vertebral fracture. (Resident #B) Findings include:	F 323		

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F 323	Continued From page 9 1.) The clinical record for Resident #B was reviewed on 2/14/11 at 1:00 p.m. Diagnoses for Resident #B included, but was not limited to, Alzheimer's disease, diabetes mellitus, and vascular dementia with behaviors. A Quarterly Minimum Data Set assessment (MDS), dated 1/20/11, indicated Resident #B had problems understanding others and of being understood by others. The MDS indicated the resident had poor decision making ability and required cueing and supervision. The MDS indicated the resident required the assistance of the staff for all transfers and toileting. A health care plan problem, last reviewed on 1/25/11, indicated Resident #B was at risk for falls due to a history of falls, Alzheimer's dementia, and antipsychotic and antidepressant medication use. One of the approaches for this problem was for the staff to utilize bed and chair alarms as ordered. A current physician's order, dated 1/4/11, indicated "bed and chair alarm on at all times, check placement and & function every shift." A nursing note, dated 1/26/11 at 3:35 p.m., included, but was not limited to, the following: "Called to living area on 200 hall by TSA [Trilogy service assistant-corporation name for a CNA]. Resident found on side on the floor. Lacerations to nose and lip. Contusion to mid forehead... MD [medical doctor] gave order to send to ER [emergency room] for eval [evaluation] and tx [treatment].... C/O [complains of] pain all over, but generalized in head." The nursing note lacked any information relating to the residents	F 323	**F 323** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B was discharged on 1/28/2011. Resident C fall circumstance form dated 11/19/2010 – the section for Equipment Inspection which asks the question if safety equipment is in place and fucntioning at the time of the incident was corrected. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Clinical Care Coordinators will review all residents with alarms to ensure alarms are in place and functioning, care plan is in place and alarms are listed on the C.N.A. Assignment sheet.	

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F 323	Continued From page 10 personal alarm having sounded at the time of the fall. A nursing note, dated 1/26/11 at 9:10 p.m., included, but was not limited to, the following: "Resident returned to facility. Has a C3 [cervical vertebrae 3] fx [fracture]. To have collar on at all x's [times].... Resident give an (sic) Hydrocodone 10/325 [a narcotic pain medication] at 2030 [8:30 p.m.] for pain.... An ED [emergency department] physician progress note, dated 1/26/11, included, but was not limited to, the following: " The patient presents following a fall. The onset was just prior to arrival. The occurrence was a single episode. Fell face forward out of wheelchair. The location where the incident occurred was at a nursing home.... ...Skin symptoms: Very large hematoma forehead with abrasion.... ...Diagnosis Closed fracture of the cervical vertebra... ...Discharge plan Condition: Stable... Patient was given the following educational materials: Cervical Collar. Follow up with: [name of physician] within 1-2 days: [name of orthopedic physician] within 1-2 days. Pt has a C3 fracture. To have collar on at all times. Nursing home to make appointment for	F 323	**Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate nurses on accurate completion of the fall circumstance assessment form. DHS or designee will re-educate nursing staff on the Falls Management Program Guidelines. **How the corrective measure will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will observe 5 residents per week times 60 days to ensure personal alarms are in place and functioning per resident plan of care.	

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F 323	Continued From page 11 patient to follow up with [name of orthopedic physician]." A "Fall Circumstance Assessment and Intervention" form, dated 1/27/11, indicated the resident had been found on the floor in the 200 hall living area on 1/26/11 at 3:35 p.m. The form indicated the resident sustained injuries on her forehead, nose, and top lip and had a C3 fx. The form contained a section for "Equipment inspection" which read "Safety equipment in place and functioning at time of incident?" There was a place to circle either yes or no. No answer was circled. During an interview with the Director of Nursing on 2/15/11 at 12:30 p.m., additional information was requested related to Resident #B's fall on 1/26/11. An "Episodic Event Form", provided by the Administrator on 2/15/11 at 1:50 p.m., dated as completed on 2/1/11, included, but was not limited to, the following: "Event What occurred? Res [resident] was found lying on floor in front of w/c [wheelchair] on 1/26/11 at 3:35 p.m. in the living area next to the 200 hall nurses station. She had large hematoma above right eye, laceration to nose, and abrasion to lip. Complained of head and nose pain. Fall was NOT witnessed. Res did not have personal alarm on her w/c as per her CP [care plan]. Sent to ER via 911. Diagnosis of C3 fracture. Resident passed away on 1/28/11 at 8:10 p.m...."	F 323	The results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent applications of guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines. **Date: March 19, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING _____ B. WING _____	C 02/17/2011

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F 323	Continued From page 12 During an interview on 2/15/11 at 1:50 p.m., the Administrator indicated the resident's personal alarm had not been on and functioning at the time of the resident's fall on 1/26/11 at 3:35 p.m. 2.) Review of a current revised facility policy dated 3/08, provided by DoN on 2/16/11 at 1:00 p.m., titled "FALLS MANAGEMENT PROGRAM GUIDELINES", included, but was not limited to, the following: "PURPOSE: Trilogy health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures.... PROCEDURE: 1. The fall risk assessment is included as part of the Admission and Monthly Nursing Assessment and Review and Circumstance forms:... ...b. Care plan interventions should be implemented that address the residents's risk factors...." This federal tag relates to complaint #IN00085707.	F 323		
F 514 SS=B	3.1-45(a)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		

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F 514	Continued From page 13 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 2 of 6 residents reviewed for completion and accuracy of fall circumstance forms in a sample of 14. (Resident #B and #C) Findings include: 1.) The clinical record for Resident #B was reviewed on 2/14/11 at 1:00 p.m. A current physician's order, dated 1/4/11, indicated "bed and chair alarm on at all times, check placement and & function every shift." A nursing note, dated 1/26/11 at 3:35 p.m., included, but was not limited to, the following: "Called to living area on 200 hall by TSA [Trilogy service assistant-corporation name for a CNA]. Resident found on side on the floor.... The nursing note lacked any information relating to the residents personal alarm having sounded at the time of the fall. A "Fall Circumstance Assessment and Intervention" form, dated 1/27/11, indicated the resident had been found on the floor in the 200 hall living area on 1/26/11 at 3:35 p.m. The form contained a section for "Equipment inspection" which read "Safety equipment in place and	F 514	**F 514** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Resident B was discharged on 1/28/2011. Resident C fall circumstance form dated 11/19/2010 – the section for Equipment Inspection which asks the question if safety equipment is in place and functioning at the time of the incident was corrected. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** DHS or designee will review the fall circumstance forms for the past 30 days to ensure the forms are complete and accurate. **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate nurses on accurate completion of the fall circumstance assessment form. DHS or designee will re-educate nursing staff on the Falls Management Program Guidelines.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 14 functioning at time of incident?" There was a place to circle either yes or no. No answer was circled. During an interview on 2/15/11 at 1:50 p.m., the Administrator indicated the resident's personal alarm had not been on and functioning at the time of the resident's fall on 1/26/11 at 3:35 p.m. 2.) The clinical record for Resident #C was reviewed on 2/16/11 at 1:25 p.m. A recapitulation of physician's orders, dated 12/1/10, indicated Resident #C had orders for bed and chair alarms due to confusion. The original date of these orders was 10/1/10. A "Fall Circumstance Assessment and Intervention" form, dated 11/19/10, indicated Resident #C had fallen on 11/18/10 at 9:45 p.m. The form contained a section for "Equipment inspection" which read "Safety equipment in place and functioning at time of incident?" The answer "yes" was circled on the form. During an interview with the Director of Nursing on 2/16/11 at 3:35 p.m., additional information was requested regarding Resident #C's fall on 11/18/10 at 9:45 p.m. A fall investigation form, provided by the Administrator on 2/17/11 at 10:00 a.m., related to the 11/18/10 fall indicated the alarm had not been working at the time of the fall. The form indicated the batteries were dead and the alarm had not sounded. This federal tag relates to complaint	F 514	**How the corrective measure will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will review fall circumstance forms after they are initiated to ensure they are complete and accurate times 60 days. The results of the audits will be presented to the Quality Assurance Committee on a monthly basis until consistent applications of guidelines are noted. Periodic evaluation will be conducted for following applicable guidelines. **Date: March 19, 2011**	

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F 514	Continued From page 15 #IN00085707. 3.1-50(a)(1) 3.1-50(a)(2)	F 514		
F9999	FINAL OBSERVATIONS State Findings: 3.1-13 ADMINISTRATION AND MANAGEMENT (g)(1) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number ((317) 383-6144) of the division. This state rule was not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure the Indiana State Department of Health was notified in a timely manner of a resident's death occurring 2 days	F9999		

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F9999	Continued From page 16 following a fall with injuries for 1 of 1 resident reviewed who expired 2 days following a fall in a sample of 14. (Resident #B) Findings include: 1.) The clinical record for Resident #B was reviewed on 2/14/11 at 1:00 p.m. Diagnoses for Resident #B included, but was not limited to, Alzheimer's disease, diabetes mellitus, and vascular dementia with behaviors. A current physician's order, dated 1/4/11, indicated "bed and chair alarm on at all times, check placement and & function every shift." A nursing note, dated 1/26/11 at 3:35 p.m., included, but was not limited to, the following: "Called to living area on 200 hall by TSA [Trilogy service assistant-corporation name for a CNA]. Resident found on side on the floor. Lacerations to nose and lip. Contusion to mid forehead... MD [medical doctor] gave order to send to ER [emergency room] for eval [evaluation] and tx [treatment].... C/O [complains of] pain all over, but generalized in head." The nursing note lacked any information relating to the residents personal alarm having sounded at the time of the fall. A nursing note dated 1/26/11 at 9:10 p.m., included, but was not limited to, the following: "Resident returned to facility. Has a C3 [cervical vertebrae 3] fx [fracture]. To have collar on at all x's [times].... Resident give an (sic) Hydrocodone 10/325 [a narcotic pain medication] at 2030 [8:30 p.m.] for pain....	F9999	**State Finding: F9999** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** No other residents were affected by this alleged deficient practice. The campus Executive Director or designee will notify the Long Term Care Division of the Indiana State Department of Health within 24 hours of a major accident or an unusual death per the facility policy entitled "Abuse and Neglect Procedural Guidelines" and in accordance with Indiana State guidelines for reporting.	

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F9999	Continued From page 17 An ED [emergency department] physician progress note, dated 1/26/11, included, but was not limited to, the following: " The patient presents following a fall. The onset was just prior to arrival. The occurrence was a single episode. Fell face forward out of wheelchair. The location where the incident occurred was at a nursing home.... ...Skin symptoms: Very large hematoma forehead with abrasion.... ...Diagnosis Closed fracture of the cervical vertebra... ...Discharge plan Condition: Stable... Patient was given the following educational materials: Cervical Collar. Follow up with: [name of physician] within 1-2 days: [name of orthopedic physician] within 1-2 days. Pt has a C3 fracture. To have collar on at all times. Nursing home to make appointment for patient to follow up with [name of orthopedic physician]." During an interview with the Director of Nursing on 2/15/11 at 12:30 p.m., additional information was requested related to Resident #B's fall on 1/26/11. An "Episodic Event Form", provided by the Administrator on 2/15/11 at 1:50 p.m., dated as completed on 2/1/11, included, but was not	F9999	**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents of the Healthcare Center have the same potential to be affected by the same alleged deficient practice. All incidents/accidents will be reviewed daily by the DHS and the Executive Director to determine if the extent of the injury would constitute a major accident. All deaths will be evaluated in light of recent events and a determination made as to whether they meet the guidelines for reporting under the facility "Abuse and Neglect Procedural Guidelines". **Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:** In-service education/training was presented March 12, 2011, to campus employees in all departments. Subject matter included "Abuse and Neglect Procedural Guidelines" identifying and reporting procedures. Leadership staff was in serviced March 10, 2011 on the process of reporting immediately to the Executive Director any major accidents incidents resulting in resident injury as well as a resident death occurring after an accident/incident.	

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F9999	Continued From page 18 limited to, the following: "Event What occurred? Res [resident] was found lying on floor in front of w/c [wheelchair] on 1/26/11 at 3:35 p.m. in the living area next to the 200 hall nurses station. She had large hematoma above right eye, laceration to nose, and abrasion to lip. Complained of head and nose pain. Fall was NOT witnessed. Res did not have personal alarm on her w/c as per her CP [care plan]. Sent to ER via 911. Diagnosis of C3 fracture. Resident passed away on 1/28/11 at 8:10 p.m...." During an interview on 2/15/11 at 2:15 p.m., the Administrator indicated she had not initially reported the resident's fall on 1/26/11 because it did not appear to meet the criteria for reporting. She indicated she still did not report the resident's death on 1/28/11 occurring 2 days after the fall on 1/26/11 until after the coroner visited the facility on 2/4/11. She indicated the coroner requested medical records for Resident #B and it was at that time that she elected to make the report to the Indiana State Department of Health (ISDH). A review of the "Fax/Incident Report", dated 2/4/11, indicated the report was faxed to ISDH on 2/4/11 at 3:00 p.m. This indicated a time period of 7 days from the day the resident expired in the facility and the unusual occurrence was faxed to ISDH. This federal tag relates to complaint #IN00085707.	F9999	**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The Executive Director, Director of Health Services, or designee will review and sign all accident/incidents within 24 hours of occurrence to determine the extent of injury. Five (5) reports will be audited weekly for the next 4 weekss and monthly X 3 months with results forwarded to the Quality Assessment and Assurance Committee for review. **Completion Date:** March 19, 2011	

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F9999	Continued From page 19 3.1-13(g)(1)	F9999		